RETINA CENTER OF MINNESOTA

Retina Center, PA
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Retina Center of Minnesota Patient Consent

Patient Name: _____ DOB:_____ Acct. Number: _____

TO OUR PATIENTS: Before you begin treatment at the Retina Center of Minnesota, the law requires that we explain your rights and responsibilities as a patient at the Retina Center of Minnesota. If you have any questions or concerns regarding your care, please call (612) 871-2292. Please read, place your initials next to each item to indicate that you agree, and then sign and date the form below.

_____ **CONSENT FOR TREATMENT:** I consent to and authorize the Retina Center of Minnesota to examine and treat me. This could include angiography, fundus photos, and other diagnostic procedures. I understand that my provider is available to explain the purpose of the procedures, and that I have the right to refuse the recommended treatment.

_____**RELEASE OF RECORDS FOR MY MEDICAL CARE OR AS REQUIRED BY LAW:** To assure proper follow-up and continuity of care, I agree that a copy of my medical records may be released to physicians and/or providers and/or to referring physicians/providers. (Our records are automatically sent to your referring physician and primary physician, if provided to us. Unless patient states otherwise.)

_____ **MEDICARE/MEDICARE ADVANTAGE ASSIGNMENT OF BENEFITS:** I authorize all payment of benefits be made to Retina Center, PA on my behalf for services rendered to me by the Retina Center of Minnesota. In consideration of clinic visits, I agree to pay Retina Center of Minnesota for all charges not covered by the payer, including any third party payer.

_____ **MEDIGAP/MEDICAID/ALL OTHER INSURANCE ASSIGNMENT OF BENEFITS:** I authorize all payment of benefits be made to Retina Center, PA on my behalf for services rendered to me by the Retina Center of Minnesota. In consideration of clinic visits, I agree to pay Retina Center of Minnesota for all charges not covered by the payer, including any third party payer.

_____**RELEASE OF MEDICAL RECORDS FOR BILLING PURPOSES:** I authorize the Retina Center of Minnesota to release to my third party payers any and all medical records needed to determine payment of benefits for services at the Retina Center of Minnesota.

_____**PATIENT'S RIGHT TO PRIVACY:** I acknowledge that I have been made aware of the Retina Center of Minnesota's privacy practices, which are posted in the reception area. If I would like a copy of the Retina Center of Minnesota's privacy practices, I will ask for one.

_____ **RELEASE OF TEST RESULTS INFORMATION:** I authorize the Retina Center of Minnesota, if they are unable to reach me at my indicated phone number, to leave my test results on my voice mail or with the answering person.

_____**STUDENT/TECHNICIAN OBSERVATION DURING SURGERY:** In the event that I require surgery for treatment, I authorize the Retina Center of Minnesota have a student/technician(s) present in the operating room, knowing they are there for educational purposes and not to participate in the surgery itself.

Patient/Other Signature: _____ Date: _____

Relationship to Patient: _____